ARIZONA STATE VETERINARY MEDICAL EXAMINING BOARD
1740 W. ADAMS ST., SUITE 4600, PHOENIX, ARIZONA 85007
PHONE (602) 364-1PET (1738) FAX (602) 364-1039
VETBOARD.AZ.GOV

COMPLAINT INVESTIGATION FORM

If there is an issue with more than one veterinarian please file a separate Complaint Investigation Form for each veterinarian

PLEASE PRINT OR TYPE

FOR OFFICE USE ONLY

Date Received: DEC 4, 2019 Case Number: 20-50

A. THIS COMPLAINT IS FILED AGAINST THE FOLLOWING:

Name of Veterinarian/CVT: Dr. PAT PAIN
Premise Name: CASA GRANDE ANIMAL HOSPITAL
Premise Address: 1645 N PINAL AVE
City: CASA GRANDE State: AZ Zip Code: 85122
Telephone: 520-836-5979

B. INFORMATION REGARDING THE INDIVIDUAL FILING COMPLAINT*:

Name: ROBERT MEYER
Address: [redacted]
City: [redacted] State: [redacted] Zip Code: [redacted]
Home Telephone: [redacted] Cell Telephone: [redacted]

**STATE LAW REQUIRES WE HAVE TO DISCLOSE YOUR NAME UNLESS WE CAN SHOW THAT DISCLOSURE WILL RESULT IN SUBSTANTIAL HARM TO YOU, SOMEONE ELSE OR THE PUBLIC PER A.R.S. § 41-1010. IF YOU HAVE REASON TO BELIEVE THAT SUBSTANTIAL HARM WILL RESULT IN DISCLOSURE OF YOUR NAME PLEASE PROVIDE COPIES OF RESTRAINING ORDERS OR OTHER DOCUMENTATION.*

RECEIVED
DEC 04 2019
BY

C. PATIENT INFORMATION (1):

Name: INDY

Breed/Species: SHEPHERD / LAB

Age: 5 Sex: MALE Color: BLACK / TAN

PATIENT INFORMATION (2):

Name: _____

Breed/Species: _____

Age: _____ Sex: _____ Color: _____

D. VETERINARIANS WHO HAVE PROVIDED CARE TO THIS PET FOR THIS ISSUE:

Please provide the name, address and phone number for each veterinarian.

DR PAT PAIN / CASA GRANDE ANIMAL HOSPITAL
1645 N. PINAL
CASA GRANDE AZ 85122
520 836 5979

E. WITNESS INFORMATION:

Please provide the name, address and phone number of each witness that has direct knowledge regarding this case.

STAFF AT CG ANIMAL HOSPITAL - DO KNOW NAMES
STAFF AT AVECCO AND
DR KAELYN PETRAS AND DR AARON GAITON AT AVECCO

[redacted]

Attestation of Person Requesting Investigation

By signing this form, I declare that the information contained herein is true and accurate to the best of my knowledge. Further, I authorize the release of any and all medical records or information necessary to complete the investigation of this case.

Signature: [signature]

Date: NOV 30, 2019

F. ALLEGATIONS and/or CONCERNS:

Please provide all information that you feel is relevant to the complaint. This portion must be either typewritten or clearly printed in ink.

SEE ATTACHED

ADDITIONAL COMMENTS

Oct. 30th:

Our dog, Indy, (Shepherd/Lab Mix) became lethargic & dazed. My home health nurse indicated something was wrong & advised me to take him to vet as her husband is a firefighter & canine for-the-blind trainer. I took him to Casa Grande Animal Hospital,Pinal Ave, Casa Grande, AZ.,our customary vet facility for 30 yrs.

* * Upon arrival, we waited for the dr. in the exam room. Indy vomitted twice (clear & some bile). Dr. Patrick Paine conducted a preliminary exam & asked if Indy had consumed poison. I replied, "yes," it was a possibility as there was some present but in a closed area. After examining the vomit, he asked the color of the poison. I replied,"green." He said, (direct quote), "it was not poison, because none of the vomit had a green tint, so it had to be a blockage." *This occurred mid-morning of the 30th. I was told that surgery was needed. I found out later they did not x-ray for a blockage because the machine had been inoperable for several days; therefore, Indy was subjected to exploratory surgery.*

Oct.31st; 7:30 p.m.

I was contacted by phone to pick Indy up & get him to a critical care hospital as they could not stop the bleeding.

(Attorney Notation) None of the following procedures were performed by the veterinarian: ultrasound, Prednisone injection, stethoscope which would indicate a blockage thru abnormal sounds.

Upon arrival, Indy was lying on top of a twin size blanket which was on the hospital floor & a tech dragged him thru the facility, into & across the parking lot & placed him in my truck. (I was told by staff, "we couldn't find our gurney).

At AVECC (Arizona Veterinary Emergency & Critical Care Center, Gilbert, AZ.), I was greeted with staff & gurney at 8:50 p.m. & Indy was taken to the back whereupon I was informed that the dr. would be there at 9 pm to examine him. However, staff indicated that without care (plasma & Vitamin K injection) being administered immediately, Indy would be dead from blood loss before the veterinarian could arrive. I replied, "do what you have to do to save him."

* * * See Attached AVECC medical records for subsequent information regarding Indy's critical care over the next 4-5 days.

During that time, I visited Indy on a daily basis & there was a tube inserted in his stomach that was then hooked back into a vein to catch

the blood & return it to his body rather than continuing on plasma. I visited him each time while he was lying in a crib, with needles & tubes in each of his 4 legs, tubes out of his stomach & a staff member with an oxygen mask being held over his nose so he could breathe. All because of loss of blood on a surgery that should never have been performed due to lack of equipment availability or other alternative treatment.

Five days later & $16,000.00, he survived Dr. Patrick Paine & Casa Grande Animal Hospital.

While exorbitant, most canine owners would have done the same had they experienced and saw the suffering of their animal. AVECC drs. & staff called several times over the next 10-14 days to check on Indy's progress.

A dog owner takes their animal to a veterinarian and expects them to do the utmost to resolve an issue and if not, refrain from drastic measures like exploratory surgery (which enclosed paperwork shows). The option of taking Indy to AVECC for critical care PRIOR to cutting him open could have been the alternative resolution thereby eliminating his near-death & our anxiety and debilitating financial burden.

Nov. 13th

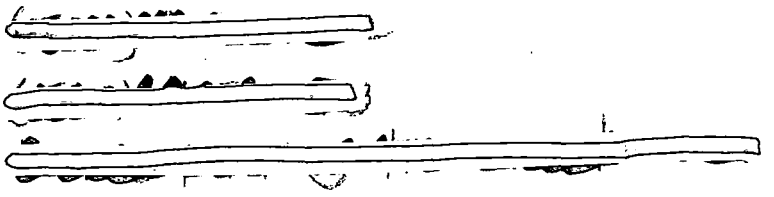
Fourteen days later, Indy was taken to AVECC for stitch (administered at CGAH) removal & found that the stitches were infected. An antibiotic was prescribed & he is well.

After contacting an attorney, it was recommended that I reach out to Lee Williams/CGAH & try to work out a resolution to charges, both theirs & AVECC's.

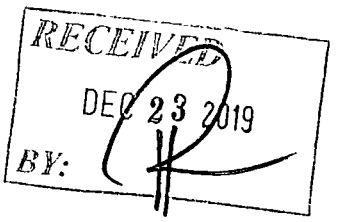
I made several attempts, to no avail. Finally, on Friday, Nov. 22nd., I made contact. Mr. Williams indicated a response would be forthcoming that day or Monday,the 25th. As yet, I have had no word.

Your consideration and examination of this complaint is most appreciated. Enclosed please find any & all documentation I have in my possession relative to this matter.

Sincerely,
Robert J. Meyer



December 18, 2019 20-50



Arizona State Veterinary Medical Examing Board
1740 W. Adams St., Ste. 4600
Phoenix, Arizona 85007

Re: Indy Meyer

Dear Sir or Madam:

October 30, 2020. Indy Meyer presented to the Casa Grande Animal Hospital for examination because of lethargy and inappetence. Initial examination results found that Indy was in a state of dehydration, gaunt appearance, splinted abdomen and mucous membranes tacky but pink. While Indy was waiting in the exam room, she did vomit a couple times. The vomitus appeared to be Phlegm with a few bits of light brown product. The bits of product had the consistency of dried peanut butter and crumbled when manipulated. I questioned Mr. Meyer about eating habits and if she was prone to getting into trash or eating other foreign objects. As I, recall his answer was that she wasn't prone to things like that. I did ask about rat poisons or other types of toxins in the area and Mr. Meyer stated that there was rat poisons in the area. I asked if the rat bait was green in nature and his statement confirmed that it was indeed green. Since the vomitus did not contain any type of green tint my medical decisions turned from the toxicity but it was still on the rule outs. I did state to Mr. Meyer that since the vomitus didn't have any green tinting it probably was not the rat bait. At this point in the examination I recommended that we preform a diagnostic work-up, blood chemistry, CBC, cPli and electrolytes and hospitalize with fluids and treat symptomatically. Mr. Meyer agreed.

Hospitalization included IV catheter, fluids and Cefazolin. I did not want to give an anti-emetic due to the possibility of a gastric foreign body being present. Blood chemistry over all was unremarkable with amylase being decreased and total T4 being decreased. Thyroid being low in this situation is most commonly euthyroid sick. Low amylase was not a concern and the cPli was normal, ruling out pancreatitis. Complete Blood Cell count revealed a high white blood cell count. Neutrophilia presentation, stress leukogram, antibiotics were already being given to address a possible infection and to protect infection from occurring with the IV catheter. Hepatic values were normal, renal values were normal, electrolytes were normal, anemia was not present and platelets were normal. In my experience, with these clinical presentations, blood chemistries, CBC's and vomiting, my first rule-out is a gastric foreign body.

October 31, 2020. Initial examination revealed mucous membranes were tacky, pink, CRT <2. Skin tenting was not appreciated as hydration was improving. Indy had vomited overnight with blood flecks noted. Indy still appeared gaunt. No other abnormalities were noted on physical exam. Since Indy had vomit with blood flecks and the previous days blood work was overall unremarkable for a toxicity or organ

dysfunction, a gastric foreign body was still at the top of my rule-outs. Abdominal radiographs were taken to aid in ruling out a gastric foreign body. In my opinion the radiographs supported the possibility of a gastric foreign body. The gastric silhouette was distended and it appeared there was product within the stomach in light of the vomiting. It was at this point I felt as though and exploratory was needed to help, diagnostically, rule out a gastric foreign body. I called the owner to inform him of the radiographic findings and recommended exploratory laparotomy.

Surgical: See surgical notes. "Premed included Dexdomitor and Butorphanol. Induced anesthesia with propofol. Intubated, placed in dorsal recumbency, clipped and scrubbed with chlorhexidine scrub solution, draped. Made ventral midline incision starting at the zyphoid extending caudally to the umbilicus. Located stomach. Fundus and body of the stomach appeared normal. Pyloric antrum and pyloric canal appeared hemorrhagic but viable. Vasculature of pyloric antrum and pyloric canal also appeared hemorrhagic. Made incision into body of the stomach via normal tissue, removed food particles, closed mucosa with 3-0 monocryl simple continuous, closed surosal/mucosal layer with 3-0 monocryl inverting mattress. Flushed abdomen, closed muscle layer with 2-0 monocryl simple continuous. Closed sub-cutaneous tissue with 2-0 monocryl simple continuous. Closed skin with staples. 0.20 ml antisedan IV". Recovery from surgery was unremarkable. A CBC was performed post surgery. Anemia was not present and a slight thrombocytopenia had developed. I continued post surgical care and medications.

Thoughts during surgery and pathology of stomach. I personally had never seen a stomach in this condition. My thoughts at the time were still foreign body as the pathology was local and not generalized throughout the stomach. Theoretically, I would expect a toxicity like rat poison to cause generalized symptoms and petechial hemorrhages, which was not the case. The hemorrhagic striations and bruising of the pyloric canal and pylorus, made me think that the stomach was trying to move a foreign body through the pylorus. All of the other tissue, body of the stomach and duodenum was normal in appearance. I summoned other veterinarians for their opinions. Thoughts were possibly a partial torsion and foreign body. Petechia was never noted in any other tissue. I found this presentation intriguing enough to ask the surgical technician to take pictures, which I have submitted to you.

I had left the clinic for the day and received a call from Dr. Fallini. Dr. Fallini informed me the surgical incision site was oozing, respirations had increased, mucous membrane pale with CRT~> 3. We decided to perform a PT/PTT. Results of the PT/PTT were increased. Packed cell volume had decreased from previous tests and BP was decreased. It was at that time we decided to give a plasma transfusion and transfer to the emergency clinic for 24 hour care. My thoughts at this time were of DIC and/or rat bait toxicity.

Patrick Paine, DVM. Associate, Casa Grande Animal Hospital

DOUGLAS A. DUCEY
- GOVERNOR -

VICTORIA WHITMORE
- EXECUTIVE DIRECTOR -

ARIZONA STATE VETERINARY MEDICAL EXAMINING BOARD

1740 W. ADAMS STREET, STE. 4600, PHOENIX, ARIZONA 85007
PHONE (602) 364-1-PET (1738) • FAX (602) 364-1039
VETBOARD.AZ.GOV

INVESTIGATIVE COMMITTEE REPORT

TO: Arizona State Veterinary Medical Examining Board

FROM: AM Investigative Committee: Robert Kritsberg, D.V.M. - Chair
Jarrod Butler, D.V.M.
Christina Tran, D.V.M.
Carolyn Ratajack
Steven Seiler

STAFF PRESENT: Tracy A. Riendeau, CVT – Investigations
Dawn Halbrook, Compliance Specialists
Mary D. Williams, Assistant Attorney General

RE: Case: 20-50
Complainant(s): Robert Meyer
Respondent(s): Patrick Paine, D.V.M. (License: 7063)

SUMMARY:
Complaint Received at Board Office: 12/4/19
Committee Discussion: 2/4/20
Board IIR: 3/18/19

APPLICABLE STATUTES AND RULES:
Laws as Amended August 2018 (Lime Green); Rules as Revised September 2013 (Yellow).

On October 30, 2019, "Indy," a 5-year-old male Shepherd Lab mix was presented to Respondent for vomiting and lethargy. Although the dog could have been exposed to rat poison, Respondent was more suspicious of a foreign body due to the dog's vomitus not being green. The dog was hospitalized for treatment and diagnostics.

The following day, radiographs were performed and Respondent suspected a foreign body and recommended surgery. Complainant agreed and surgery was performed. The abdominal explore was negative. The dog recovered and did well initially, however, later that evening the dog began to decline. A coagulation profile revealed prolonged coagulation time; a plasma transfusion was performed and it was recommended and approved to transfer the dog to an emergency facility for enhanced care.

The dog was admitted to an emergency facility for diagnostics and treatment. It was eventually determined that the dog had eaten anticoagulant rodenticide.

Complainant was noticed and was unavailable.
Respondent was noticed and appeared telephonically. Attorney David Stoll appeared.
Consulting Veterinarian, Kaelyn Petras, DVM, appeared telephonically.

The Committee reviewed medical records, testimony, and other documentation as described below:

- Complainant(s) narrative: *Robert Meyer*
- Respondent(s) narrative/medical record: *Patrick Paine, DVM*
- Consulting Veterinarian(s) narrative/medical record: *Lorinda Fallini, DVM – Casa Grande Animal Hospital; Kaelyn Petras, DVM - Arizona Veterinary Emergency & Critical Care.*

PROPOSED 'FINDINGS of FACT':

1. On October 30, 2019, the dog was presented to Respondent due to lethargy and vomiting. Upon exam, the dog had a weight = 85.1 pounds, a temperature = 101.1 degrees, a heart rate = 130bpm and a respiration rate = 20bpm; mucous membranes tacky. The dog vomited in the exam room which consisted of phlegm and a few brown bits of foreign material. According to Respondent, the brown bits were the consistency of dry peanut butter. Complainant reported that the dog did not typically get into the trash or eat foreign objects. Respondent asked about rat poison; Complainant confirmed that rat poison was in the area and the bait was green. Since the vomitus was not green, Respondent did not feel the vomiting was due to the rat poison. Respondent stated that toxicity was still on his differential list. Respondent recommended blood work and hospitalization for fluids and to treat the dog's symptoms.

2. Blood work revealed the following abnormalities:

AMY	*497*	*(500-1500)*
TT4	*0.9*	*(1-4)*
WBC	*19.89*	*(5.05-16.76)*
NEU	*17.76*	*(2.95-11.64)*
EOS	*0.01*	*(0.6-1.23)*

3. An IV catheter was placed and the dog was started on LRS fluids at 170mLs/hr and was administered Cefazolin 1g – 2.5mLs slowly IV. The IV fluids were decreased to 110mLs/hr overnight. Respondent stated that he did not want to give the dog an antiemetic due to the possibility of a gastric foreign body being present.

4. The following morning (10//31/19), the dog had a temperature = 101.7 degrees, a heart rate = 120bpm and a respiration rate = 26rpm; urinated outside. A new bag of IV fluids were started (fluid bag size unknown; TVI not recorded), the dog was offered canned and dry i/d – at the canned food. The dog was administered:

a. Cefazolin 250mg/mL – 2.5mL (route unknown); and
b. Famotidine 10mg/mL – 1.0mL (route unknown).

5. Respondent examined the dog, he noted that the dog vomited blood flecks during the night. Abdominal radiographs were performed and revealed the gastric silhouette was distended and there was an appearance of product in the stomach according to Respondent (The small animal radiograph machine was not working, however, the large animal unit was, which is how Respondent radiographed the dog). At this point, Respondent felt exploratory laparotomy was warranted and contacted Complainant with his recommendation; Complainant agreed to surgery.

6. The dog was pre-medicated with dexdomitor and butorphanol IV, induced with propofol IV and maintained on isoflurane and oxygen. Once the dog was prepped, Respondent entered

the abdomen and located the stomach. Fundus and body of the stomach appeared normal. Pyloric antrum and pyloric canal appeared hemorrhagic but viable and the vasculature of pyloric antrum and pyloric canal also appeared hemorrhagic. An incision was made into the stomach, food particles were removed – no foreign body was identified – the stomach was closed and the abdomen was flushed and closed. The dog was administered antisedan and cefazolin IV. Respondent instructed staff to continue IV fluids at 110mL/hr and he left for the day.

7. Later that day, Respondent's associate Dr. Fallini was advised by technical staff that the dog appeared more depressed. She evaluated the dog and noted generalized weakness, pale-pink mucous membranes, and tachycardia. Dr. Fallini was also concerned about the amout of seepage of blood from the incision site. A CBC and coagulation profile was performed and revealed prolonged coagulation times. Dr. Fallini started a plasma transfusion on the dog and contacted Respondent to give him an update – he agreed with the treatment plan and offered to return to the premises; Dr. Fallini declined. Respondent advised Dr. Fallini to contact Complainant and refer the dog to an emergency facility for enhanced care. Complainant agreed.

8. Complainant and a staff member of Respondent's transferred the dog to Arizona Veterinary Emergency & Critical Care. Upon arrival, Dr. Petras evaluated the dog – he was obtunded, markedly pale and hypotensive. The abdomen was bruised at the incision site and painful. The dog had muffled heart sounds with a severe sinus tachycardia. He had pericardial effusion with cardiac tamponade, no obvious pleural effusion and mild peritoneal effusion. Blood gas revealed severe metabolic acidosis, hyperlactatemia, ionized hypocalcemia with a PCV = 18% and prolonged PT/PTT times.

9. The dog was treated with fluid bolus and a pericardiocentesis which ruptured the pericardial sac. The dog's heart rate improved.

10. Dr. Petras discussed her findings with Complainant and Respondent's staff and the presence of pericardial effusion. She discussed potential causes and recommended an echocardiogram to rule out common causes of pericardial effusion. They also discussed the severe anemia and recommended blood and plasma transfusion. Complainant asked if this could have been the problem from the beginning – Dr. Petras was unsure as she had not seen any thoracic radiographs and advised that pericardial effusion can cause vomiting, weakness/lethargy, and polydipsia. Complainant agreed to hospitalization for diagnostics and treatments.

11. It was eventually discovered that the dog had eaten anticoagulant rodenticide and was hospitalized for treatment for three days and was discharged successfully.

COMMITTEE DISCUSSION:

The Committee discussed that they could understand why Respondent initially suspected the dog had a foreign body; blood work was normal; although, radiographs could have been better. Furthermore, if it had been a foreign body, the longer the wait, the worse it gets. It appears from Complainant's narrative that he was also unsure if the dog had been poisoned.

There was a lot of hindsight in this case – more in depth questioning and diagnostics may have

made the poisoning more apparent.

The Committee also discussed that Respondent was focused on the foreign body and was not letting anything deter him from that diagnosis. Just because the dog did not vomit anything green, with an unknown potential exposure to rodenticide, it should not rule out the possibility of rat poisoning. The hospital had the ability to perform a PT/PTT in-house and with a possible exposure, it should have been ruled out prior to surgery. It did not appear that the radiographs were of diagnostic quality which could be why Respondent did not charge Complainant for them.

As time progressed, as what happens with rodenticide, it became clearer that rodenticide was the cause of the dog's issues.

COMMITTEE'S PROPOSED CONCLUSIONS of LAW:

The Committee concluded that no violations of the *Veterinary Practice Act* occurred.

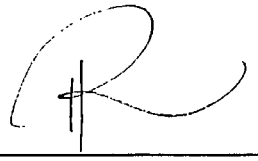
COMMITTEE'S RECOMMENDED DISPOSITION:

Motion: It was moved and seconded the Board:

Dismiss this issue with no violation.

Vote: The motion was approved with a vote of 5 to 0.

The information contained in this report was obtained from the case file, which includes the complaint, the respondent's response, any consulting veterinarian or witness input, and any other sources used to gather information for the investigation.



Tracy A. Riendeau, CVT
Investigative Division